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BEFORE THE
BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: DEBRA ERICSON PASCHALL, a.k.a. DEBRA LYNN PASCHALL, a.k.a. DEBRA LYNN REYNOLDS, a.k.a. DEBRA LYNN ERICSON 5515 Charlotte Lane Riverside, CA 92509 Vocational Nurse License No. VN 157620 Respondent.	Case No. VN-2005-1429 **ACCUSATION**

Complainant alleges:

PARTIES

1. Teresa Bello-Jones, J.D., M.S.N., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Vocational Nursing and Psychiatric Technicians ("Board"), Department of Consumer Affairs.

2. On or about June 19, 1992, the Board issued Vocational Nurse License No. VN 157620 to Debra Ericson Paschall, a.k.a. Debra Lynn Paschal,l a.k.a. Debra Lynn Reynolds, a.k.a. Debra Lynn Ericson ("Respondent"). The Vocational Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2009, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code ("Code") unless otherwise indicated.

4. Section 2875 of the Code provides, in pertinent part, that the Board may discipline the holder of a vocational nurse license for any reason provided in Article 3 (commencing with section 2875) of the Vocational Nursing Practice Act.

5. Section 2878 of the Code states:

"The Board may suspend or revoke a license issued under this chapter [the Vocational Nursing Practice Act (Bus. & Prof. Code, 2840, et seq.)] for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual nursing functions."

6. Section 2878.5 of the Code states:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Vocational Nursing Practice Act] it is unprofessional conduct for a person licensed under this chapter to do any of the following:

. . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to narcotics or dangerous drugs as specified in subdivision (b)."

7. California Code of Regulations, title 16, section 2519, states:

"As set forth in Section 2878 of the Code, gross negligence is deemed unprofessional conduct and is a ground for disciplinary action. As used in Section 2878 'gross negligence' means a substantial departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent licensed vocational nurse, and which has or could have resulted in harm to the consumer. An exercise of so slight a degree

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of care as to justify the belief that there was a conscious disregard or indifference for the health, safety, or welfare of the consumer shall be considered a substantial departure from the above standard of care."

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

TERMINOLOGY

9. Vicodin is a Schedule III controlled substance pursuant to Health and Safety Code section 11056 (e)(4), and a dangerous drug within the meaning of Business and Professions Code section 4022. Vicodin is a brand name for the generic drug Hydrocodone 5mg with APAP and is used to treat pain. It is also known as dihydrocodeinone with the non-narcotic substance acetaminophen.

10. Omnicell is a trade name for the automated single-unit dose medication dispensing system that records information such as patient name, physician orders, date and time the medication is withdrawn, and the name of the licensed individual who withdraws it. Each user/operator is given a "user ID" or code number to operate the control panel. The user is required to enter a second code "PIN" number to gain access to the medications. Sometimes only portions of the withdrawn narcotics are given to the patient. The portions not given to the patient are referred to as "wastage". This waste must be witnessed by another authorized user and is also recorded by the Omincell machine.

INTRODUCTION

11. Respondent was employed as a licensed vocational nurse in the Neurological Care Unit of the Community Hospital of San Bernardino ("CHSB") from about February 6, 2006 to about June 13, 2006. During this period, Respondent failed to properly chart the withdrawal and wastage of controlled substances in the following instances:

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12. **PATIENT A**

Physician's Orders: Vicodin 1 tablet as needed every 4 hours via G-tube as needed for pain.

5/04	04:48	Vicodin ES x 1 tab	Charted on the MAR
5/08	00:58	Vicodin ES x 1 tab	Not documented on the MAR, no returns or wastage documented. Nurses notes indicate "no s/s pain."
5/09	20:04	Vicodin ES x 1 tab	Not documented on the MAR, no returns or wastage documented. Nurses notes at 2000 indicate "pt is resting comfortably, in no acute distress."

Summary on Patient A: Respondent withdrew a total of 3 Vicodin tablets, with 1 tablet charted on the MAR as being administered and none wasted. A total of 2 Vicodin tablets were unaccounted for.

13. **PATIENT B**

Physician's Orders: Vicodin 1 tablet every 6 hours as needed for mild pain. Vicodin 2 tablets every 6 hours as needed for severe pain.

4/02	00:33	Vicodin x 2 tabs	Charted on the MAR at 00:30 for "low grade temp, s/s pain."
4/19	05:35	Vicodin x 2 tabs	Not documented on the MAR, no returns or wastage documented. Nurses notes indicate "no s/s pain."
	21:51	Vicodin x 2 tabs	On MAR, Respondent had her initials only. Nurses notes at 2400 indicate "Vicodin given for s/s of pain, facial grimacing."
4/20	06:11	Vicodin x 2 tabs	On the MAR, Respondent had her initials only. Nurses notes at 0630 indicate "Remains stable, no change in status."
4/21	01:33	Vicodin x 2 tabs	Not documented on the MAR. Nurses notes at 2400 indicate "Patient is awake with facial grimace, prn Ativan and Vicodin given.

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Summary on Patient B: Respondent withdrew a total of 10 Vicodin tablets, with 6 tablets charted on the MAR as being administered and none wasted. A total of 4 Vicodin tablets were unaccounted for.

14. **PATIENT C**

Physician's Orders: Vicodin 1 tablet every 4 hours as needed.

5/14	19:58	Vicodin x 1 tab	MAR not initialed, but nurses notes record 2000 dose for "facial grimacing."
	23:19	Vicodin x 1 tab	Not documented on the MAR, no returns or waste documented.
5/15	07:20	Vicodin x 1 tab	On the MAR, Respondent had her initials only. Medication notes not completed on the reverse side.
5/16	05:07	Vicodin x 1 tab	Charted on the MAR, medication notes "facial grimacing."
5/30	21:46	Vicodin x 1 tab	On the MAR, Respondent had her initials only. Nurses notes indicate "no s/s pain."
5/31	21:23	Vicodin x 1 tab	On the MAR, Respondent had her initials only. Nurses notes indicate "no s/s pain."

Summary on Patient C: Respondent withdrew a total of 6 Vicodin tablets with 4 tablets charted on the MAR as being administered and none wasted. A total of 2 Vicodin tablets were unaccounted for.

15. **PATIENT D**

Physician's Orders: Vicodin 1 tablet every 4 hours for mild pain; Vicodin 2 tablets every 4 hours for severe pain.

5/30	20:41	Vicodin x 2 tabs	On the MAR at 2030 for "c/o Pain," Nurses notes at 1900 indicate "Denies pain."
5/31	05:47	Vicodin x 2 tabs	Not documented on the MAR, no returns or waste documented.

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5/31	20:35	Vicodin x 2 tabs	On the MAR, Respondent had her initials only. Nurses notes at 1900 indicate "No s/s respiratory distress or pain."

Summary on Patient D: Respondent withdrew a total of 6 Vicodin tablets, with 4 tablets charted on the MAR as being administered and none wasted. A total of 2 Vicodin tablets were unaccounted for.

16. **PATIENT E**

Physician's Orders: Vicodin 2 tablets every 4 hours as needed.

5/01	00:15	Vicodin x 2 tabs	Respondent initialed next to one dose only.
	03:04	Vicodin x 2 tabs	No details in the medication notes on the reverse side of the MAR. Nurses notes indicate "Generalized" pain, with no time or intervention noted and only 3 hours between removals.
5/30	20:20	Vicodin x 2 tabs	On the MAR, Respondent had her initials only. Nurses notes at 2000 state "c/o pain, crying, Vicodin 2 tabs."
5/31	04:51	Vicodin x 2 tabs	Not documented on the MAR, no returns or waste documented.
5/31	20:01	Vicodin x 2 tabs	On the MAR, Respondent had her initials only. Nurses notes at 1950 state "c/o pain, Vicodin 2 tabs given."

Summary on Patient E: Respondent withdrew a total of 10 Vicodin tablets, with 6 tablets charted on the MAR as being administered and none wasted. A total of 4 Vicodin tablets were unaccounted for.

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17. **PATIENT F**

Physician's Orders: Vicodin 1 tablet every 6 hours as needed.

4/18	20:53	Vicodin x 1 tab	Not documented on the MAR, no returns or waste documented. Nurses notes at 2000 state "no s/s pain."
4/19	21:25	Vicodin x 1 tab	On the MAR, Respondent had her initials only. No detail in the medication notes on the reverse side of the MAR. Nurses notes state "no s/s pain."
4/20	21:03	Vicodin x 1 tab	On the MAR, Respondent had her initials only. No detail in the medication notes on the reverse side of the MAR. Nurses notes state "no s/s pain."

Summary on Patient F: Respondent withdrew a total of 3 Vicodin tablets, with 2 tablets charted on the MAR as being administered and none wasted. A total of 1 Vicodin tablet was unaccounted for. Respondent was the only nurse to remove Vicodin for this patient during a 7-day period.

18. **PATIENT G**

Physician's Orders: Vicodin 1 tablet every 4 hours as needed for moderate pain; Vicodin 2 tablets every 4 hours for severe pain.

4/24	20:09	Vicodin x 1 tab	Documented on the MAR at 2130 by another nurse.
4/25	20:36	Vicodin x 2 tabs	On the MAR, Respondent had her initials only. Nurses notes at 2000 indicate "c/o increasing pain, generalized, requests Vicodin."
	23:43	Vicodin x 1 tab	Not documented on the MAR, no returns or wasted documented. Doses removed 3 hours apart.

Summary on Patient G: Respondent withdrew a total of 4 Vicodin tablets, with 3 tablets charted on the MAR as being administered and none wasted. A total of 1 Vicodin tablet was unaccounted for.

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19. **PATIENT H**

Physician's Orders: Vicodin 1 tablet every 4 hours as needed.

5/18	20:19	Vicodin x 1 tab	Charted on the MAR at 2020 for "c/o gen pain."
5/19	00:05	Vicodin x 1 tab	Not documented on the MAR, no returns or waste documented.

Summary on Patient H: Respondent withdrew a total of 2 Vicodin tablets, with 1 tablet charted on the MAR as being administered and none wasted. A total of 1 Vicodin tablet was unaccounted for.

20. **Total Discrepancies of Narcotics among Patients A - H =17 Vicodin Tablets**

21. **PATIENT I**

On or about June 2, 2006, Respondent was assigned to the care of Patient I. At 2337 and 2338 hours, Respondent withdrew two Phenobarbital liquid 30-mg/7.5 ml from the Omnicell but did not administer to Patient I. Respondent also withdrew Ativan from the Omnicell. There was no physician order for Ativan tablet for Patient I. Respondent told her supervisors she administered Ativan to Patient I. There was no documentation in the MAR or in the nurses notes that Patient I received either the Ativan or the Phenobarbital.

22. **PATIENT J**

On or about June 2, 2006, Respondent was assigned to the care of Patient J. At 2100 hours, Respondent failed to administer the dose of Heparin 5000 units, nor did she sign the MAR as having administered the medication.

23. **PATIENT K**

On or about June 2, 2006, Respondent was assigned to the care of Patient K. At 1800 hours, Respondent failed to administer the dose of Reglan 10 mg, nor did she sign the MAR as having administered the medication.

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24. **PATIENT L**

On or about June 2, 2006, Respondent was assigned to the care of Patient L. At 2400 and 0600 hours, Respondent failed to administer doses of Baclofen 20 mg, nor did she sign the MAR as having administered the medication.

25. **PATIENT M**

On or about March 11, 2006, Respondent was assigned to the care of Patient M. The physician ordered 1250 mg of Valproic acid to be administered 5 times a day to this patient. Respondent failed to administer the dose of Valproic acid at 0100 hours to Patient M, failed to chart Patient M's acid level, nor did she sign in the MAR as having administered the medication.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

26. Respondent is subject to disciplinary action under Code section 2878, subdivision (a)(1) in conjunction with California Code of Regulations, title 16, section 2519 for gross negligence, in that Respondent failed to follow hospital policy and procedure in medication administration and the handling of narcotics. The circumstances are as described above in paragraphs 11-25, and are incorporated herein by reference.

SECOND CAUSE FOR DISCIPLINE

(Falsify, Make Incorrect, Inconsistent or Unintelligible Entries Re: Drugs)

27. Respondent is subject to disciplinary action under Code section 2878.5, subdivision (e) for unprofessional conduct, in that she falsified, or made grossly incorrect or inconsistent records pertaining to narcotics or dangerous drugs. The circumstances are as described above in paragraphs 11-25, and are incorporated herein by reference.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

28. Respondent is subject to disciplinary action under Code section 2878, subdivision (a) section for unprofessional conduct. The circumstances are as described above in paragraphs 11-25, and are incorporated herein by reference.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Vocational Nurse License Number VN 157620, issued to Debra Ericson Paschall, a.k.a. Debra Lynn Paschall, a.k.a. Debra Lynn Reynolds, a.k.a. Debra Lynn Ericson;

2. Ordering Debra Ericson Paschall, a.k.a. Debra Lynn Paschall, a.k.a. Debra Lynn Reynolds, a.k.a. Debra Lynn Ericson to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: January 30, 2008

TERESA BELLO-JONES, J.D., M.S.N., R.N.
Executive Officer
Board of Vocational Nursing and Psychiatric Technicians
State of California
Complainant

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